that marital therapy is not the preserve of the psychiatrist or social worker; the initial assessment is with the family physician. This is a sensible statement. The family physician is in the unique position of seeing the patient in relation to the community and is thus able to understand important intangible aspects of treatment that are frequently overlooked.

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Investigation of extrahepatic bile duct obstruction

While I agree that the unusual hepatotoxic reaction to quinidine reported by Dr. David B. Hogan and colleagues (*Can Med Assoc J* 1984; 130: 973) is interesting, I question the investigation that the patient underwent. Ultrasound examination of the abdomen failed on two occasions to reveal evidence of biliary obstruction, and a liver biopsy showed no evidence of extrahepatic bile duct obstruction. Why, then, with this bit of evidence, was the patient subjected to endoscopic retrograde cholangiopancreatography (ERCP) twice and to transhepatic cholangiography?

The indication for ERCP in obstructive jaundice specifically includes demonstration of dilated intrahepatic or extrahepatic ducts by ultrasonography. If the ducts are not dilated ERCP and transhepatic cholangiography are both contraindicated since they are invasive techniques with inherent complications.

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[Dr. Hogan replies:]

In spite of the negative results of ultrasonography we suspected extrahepatic bile duct obstruction in our patient. In 5% to 15% of patients with proven obstruction ultrasonography gives negative results.[1] In addition, a liver biopsy often fails to distinguish between extrahepatic and intrahepatic cholestasis.[2] Since we felt on the basis of the clinical results that ductal obstruction was still likely, and since the patient was becoming worse, we elected to attempt direct visualization of the bile ducts. Because of the availability of skilled personnel we started with ERCP. Unfortunately, visualization was unsuccessful, so we performed percutaneous cholangiography. The patient became clinically better only after these investigations had been completed. We followed the approach suggested by Scharschmidt and colleagues.[1]

Dr. Hershfield's point is well taken, but we felt that in the context of the clinical situation our approach was appropriate.

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References

1. SCHARSCHMIDT BF, GOLDBERG HI, SCHMID R: Approach to the patient with cholestatic jaundice. *N Engl J Med* 1983; 308: 1515–1519
2. LANCE P, BEVAN PG, HOULT JG et al: Liver biopsy in "difficult" jaundice. *Br Med J* 1977; 2: 236

Excellent response of pathologic jealousy to pimozide

Pathologic jealousy is a delusional symptom that may occur in association with chronic alcoholism, organic brain disorder, schizophrenia or affective disorder,[1] or it may present as the only delusion in paranoia (sometimes, but not always, in association with chronic alcoholism).[2] The symptom is most often described in men but occurs in both sexes. It is probably associated with violence more often in men; murder of the sexual partner has been reported. The wives of some pathologically jealous men become housebound because they are terrified of the abuse and assault they incur if they are out of sight of their spouses for more than a very short time. The delusion in the paranoic form is persistent, unremitting and totally unresponsive to discussion or argument.

Pathologic jealousy can be a difficult and unpleasant disorder to deal with. If it is symptomatic of another psychiatric illness the treatment is of that illness. Treatment of the paranoic form has always been very unsatisfactory, but two cases of excellent response to pimozide have been reported.[3,4] I report a third such case.

Case report

A 48-year-old man, employed as a labourer, complained that his wife had been consistently unfaithful to him for the previous 18 months. He had been a heavy drinker when he was younger but now drank moderately. He had no history of other psychiatric disorders. His physical health was good except for a 5-year history of moderate hypertension, for which he was receiving hydrochlorothiazide and a potassium supplement.

The patient first became suspicious when he discovered that his wife was taking contraceptive pills. He believed that she would have intercourse during the minute or two that she would take to go to the washroom during the night. He also believed that men driving past the house at night flashed their lights in a significant way and that men rang coded messages to his wife on the telephone.

When interviewed the patient was totally preoccupied with his delusional concerns, was extremely tense and agitated, and could not be persuaded that his beliefs were false. There was no evidence of major affective disorder, schizophrenia or organic brain disorder. His wife was very distressed, and she and her family denied the patient's accusations. Both husband and wife claimed that he had never been violent towards her, but his accusations were so bitter that she had become almost housebound and had taken an overdose of pills a few weeks before.

A diagnosis of pathologic jealousy was made, and pimozide, 2 mg daily for 3 days and then 4 mg daily, was prescribed. Within several days the patient's distress had abated, and over the next 2 to 3 weeks his

delusions totally vanished. Three months later he was still well, and his wife was relaxed and contented. At the time of writing the patient was still taking pimozide, 2 mg daily.

Comments

Some cases of pathologic jealousy, such as the one I have described, are monosymptomatic delusional states.[5] There are many descriptions in the literature of similar delusional states in which the delusional content is hypochondriacal, and in recent years a large proportion of cases of these "monosymptomatic hypochondriacal psychoses" have been shown to respond to pimozide.[6] It now appears possible that some patients with pathologic jealousy may also respond favourably to this medication. If other practitioners have had similar experience with this condition I would be grateful to hear from them.

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References

1. SEEMAN MV: Pathological jealousy. *Psychiatry* 1979; 42: 351–361
2. MUNRO A: Paranoia revisited. *Br J Psychiatry* 1982; 141: 344–349
3. DORIAN BJ: Monosymptomatic hypochondriacal psychosis [C]. *Can Psychiatr Assoc J* 1979; 24: 377
4. POLLOCK BG: Successful treatment of pathological jealousy with pimozide [C]. *Can J Psychiatry* 1982; 27: 86–87
5. MUNRO A: Diagnosis and treatment of paranoid disorders. *Perspect Psychiatry* 1982; 1: 1–5
6. Idem: Monosymptomatic hypochondriacal psychosis. *Br J Hosp Med* 1980; 24: 34–38

Spontaneous dissolution of gallstones?

I read with great interest the excellent article by Dr. Albert Akierman and colleagues on cholelithiasis in a preterm infant (*Can Med Assoc J* 1984; 131: 122–123). I agree that prolonged fasting and total parenteral nutrition (TPN) probably contributed to the formation of gallstones. While it is also probably true that introduction of oral feeding and discontinuation of TPN resulted in the spontaneous disappearance of the gallstones, there is a remote possibility that the gallstones might have passed through a fistula into the bowel. The presence of gallstones in the bowel does not necessarily result in gallstone ileus. The diagnosis may be missed if the stones are passed outside the body and are unnoticed in the stool.[1] The fistula is not always demonstrable, as it usually resolves with time; this is why when cholecystectomy is done following gallstone ileus the fistula between the gallbladder and the bowel often cannot be found.[2] The presence of a sizeable gallstone in the bowel speaks for the fact that the fistula was there.

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References

1. ZWEMER FL, COFFIN-DWART VE, CONWAY MJ: Biliary enteric fistulas. Management of 47 cases in native Americans. *Am J Surg* 1979; 138: 301–304
2. SCHWARTZ SI: Gallbladder and extrahepatic biliary systems. In SCHWARTZ SI, SHIRES GT, SPENCER FC et al (eds): *Principles for Surgery*, McGraw, New York, 1984: 1307–1343

The gremlins are back [correction]

Once again our gremlins have absconded with some of our copy. In the Sept. 1, 1984 issue of *CMAJ* (131: 453–456) the legends for the abscissas of Figs. 1 and 5 in the article "Birth weight, length, head circumference and bilirubin level in Indian newborns in the Sioux Lookout Zone, northwestern Ontario", by Dr. Margaret Munroe and colleagues, are missing. The legends should read "Weight in g" and "Head circumference in cm" respectively. We apologize for any consternation this may have caused the authors or readers.—Ed.